PRIOR AUTHORIZATION

ADULTS

Psychologist, Psychiatrist, PCNS, RHC, FQHC

The Psychology/Counseling bulletin, dated October 01, 2004, outlined a new Prior Authorization (PA) process. Prior Authorization approves the medical necessity of the requested service and does not guarantee payment. The patient must meet eligibility requirements and the provider must be enrolled and eligible to bill the services.

Effective for dates of service November 01, 2004, and after, many Psychological services provided to adults (21 years of age or older) must be prior authorized when performed by a Psychiatrist, Psychologist, Psychiatric Clinical Nurse Specialist (PCNS), Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC).

Effective for dates of service May 01, 2005 and after Individual Interactive Therapy for adults is not allowed under the four (4) hours of non-prior authorized services. All Individual Interactive Therapy must be prior authorized.

Adult services provided by LCSWs and LPCs are not covered by Missouri Medicaid, except in an RHC or FQHC setting.

Family Therapy Without the Patient Present requires prior authorization for adults regardless of age.

CHILDREN

In subsequent phases, the Division of Medical Services (DMS) will implement new Prior Authorization measures for children for most Psychology/Counseling services.

Effective for dates of service May 01, 2005 and after, the PA process was implemented for children, 0 through 20 years of age, who are not in state custody or residing in a residential treatment facility.

The PA process for children in state custody or residing in a residential treatment facility will be implemented at a later date. Providers will be notified via bulletins regarding the effective dates for these groups of children.

The requirement for Prior Authorization will include services provided by a Psychiatrist, Psychologist, PCNS, Provisionally Licensed Clinical Social Worker

(PLCSW), Licensed Clinical Social Worker (LCSW), Provisionally Licensed Professional Counselor (PLPC), Licensed Professional Counselor (LPC), RHC, or FQHC.

ADULTS AND CHILDREN

Codes Requiring PA – Psychologist, Psychiatrist, PCNS, RHC, and FQHC

Assessment – Interactive 90802 (30 minute session)
Maximum of 2 units per rolling year

Individual Therapy 90804 / 90810 (20 – 30 minute session)
Individual Therapy 90806 / 90812 (45 – 50 minute session)
Maximum of 1 unit, either 30 minute or 45-50 minute session per day;
Maximum of 5 units, any combination of 30 minute or 45-50 minute sessions per month

Family Therapy 90846 / 90847 (30 minute session)
Maximum of 2 units per procedure per day;
Maximum of 10 units per month

Group Therapy 90853 (30 minute session)
Maximum of 3 units per day;
Maximum of 15 units per month

Hypnotherapy 90880 (no time frame noted)

Aphasia Assessment 96105 (60 minute session)

Developmental testing 96111 (60 minute session)

Neurobehavioral testing *96116* (60 minute session)

Effective for dates of service 07-01-05 and after, 90899 unlisted psychiatric services or procedures will no longer be a payable code.

The AH modifier must be included when billing claims for Psychologists.

Codes Not Requiring PA – Psychologist, Psychiatrist, PCNS, RHC and FQHC

Assessment – Insight	90801 (30 minute session) Maximum of 6 units per rolling year
Testing	96101 / 96103 (60 minute session) Maximum of 4 units per rolling year
Individual Inpatient	90816 / 90823 (20 – 30 minute session)
Individual Inpatient	90818 / 90826 (45 – 50 minute session)
Evaluation Inpatient Records	90885 (no time frame noted)
Evaluation and Management codes	
Crisis Intervention	**S9484 (60 minute session)** **Maximum of 6 units per rolling year.**

Regardless of Prior Authorization, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units over the daily and monthly limits will no longer be reimbursed.

CHILDREN

Codes Requiring PA – PLCSW, LCSW, PLPC, LPC

Assessment – Interactive 90802 (30 minute session)
Maximum of 2 units per rolling year

Individual Therapy 90804 / 90810 (20 – 30 minute session)
Individual Therapy 90806 / 90812 (45 – 50 minute session)
Maximum of 1 unit, either 30 minute or 45-50 minute session per day;
Maximum of 5 units, any combination of 30 minute or 45-50 minute sessions per month

Family Therapy 90846 / 90847 (30 minute session)
Maximum of 2 units per procedure per day;
Maximum of 10 units per month

Group Therapy 90853 (30 minute session)
Maximum of 3 units per day;
Maximum of 15 units per month

Codes Not Requiring PA – PLCSW, LCSW, PLPC, LPC

Assessment – Insight 90801 (30 minute session)
Maximum of 6 units per rolling year

Individual Inpatient 90816 / 90823 (20 – 30 minute session)

Individual Inpatient 90818 / 90826 (45 – 50 minute session)

Crisis Intervention S9484 (60 minute session)
Maximum of 6 units per rolling year.

Regardless of Prior Authorization, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units over the daily and monthly limits will no longer be reimbursed.

ALL PROVIDERS

Effective for dates of service December 01, 2005 and after, Testing and Diagnostic Assessment (Insight-90801) have been removed for the Prior Authorization process for most clients.

Diagnostic Assessment (Interactive-90802) continues to require Prior Authorization regardless of the age of the client.

Testing is still limited to independent Psychiatrists and Psychologists or those providing services through an RHC or FQHC. Missouri Medicaid does not reimburse for testing when performed by an LPC, PLPC, LCSW or PLCSW regardless of the setting.

All services for all children under the age of three (3), including those in state custody and residential care facilities, continue to require Prior Authorization. This includes Testing and Assessment services.

DEFINITIONS

Crisis Intervention

The definition of crisis intervention is: "A face-to-face contact to diffuse a situation of immediate crisis. The situation must be of significant severity to pose a threat to the patient's well being or is a danger to him/herself or others". Crisis intervention services cannot be scheduled nor can they be prior authorized.

Individual Interactive Therapy

Individual Interactive Therapy is typically furnished to children and involves the use of physical aids and non-verbal communication to overcome barriers to interaction between the clinician and the patient who has not yet developed, or has lost, either the expressive language communications skills to explain symptoms and response to treatment, or the receptive communication skills to understand the clinician if ordinary adult language were used for communication.

Family Therapy

Family therapy is the treatment of the members of a family together, parent(s) and child(ren) rather than an individual "patient". The family unit is viewed as a social system that affects all its members. A parent must be present to be considered Family Therapy. (Refer to Section 4.3)

Group Therapy

Group Therapy uses group dynamics and peer interactions to increase understanding and improve social skills. Group therapy is a medically necessary, time-limited, goal-specific, face-to-face interaction based upon planned interventions documented in the Treatment Plan. Groups are limited to a minimum of three (3) but no more than ten (10) patients.

(Providers should refer to the April 13, 2005 bulletin for more detailed information regarding these definitions.)

GUIDELINES - Adults

A Prior Authorization (PA) process for psychological services for adults was implemented November 01, 2004. In order to facilitate changes in Prior Authorization policy, all PAs for adult psychological services were closed effective December 31, 2005. New guidelines for the adult PA process were implemented effective January 01, 2006.

Independent LCSWs and LPCs may not see adults and should not request prior authorization for Psychology/Counseling services for clients 21 year of age or older.

LCSWs and LPCs who are members of an FQHC or RHC may provide adult services as part of the clinic. These services will require prior authorization but the request is made using the facility provider number.

The first four (4) hours of psychotherapy services for adults do not require prior authorization. These four (4) hours are intended to allow the provider opportunity to assess the patient's need for ongoing treatment. The first four (4) hours are per patient, per provider, per rolling year. These four (4) non-Prior Authorized hours do not include Family Therapy without the patient present or Individual Interactive Therapy. All hours of these therapies must be Prior Authorized before rendering services.

Providers who have rendered therapy services to a recipient within the past 12 months will be considered as having used their four (4) non-prior authorized hours.

After the initial 4 hours, when it is determined that ongoing services are medically necessary, Prior Authorization must be obtained. This Prior Authorization must be requested before rendering additional services. In order not to interrupt services it would be best to request authorization before all 4 hours are used. The first PA request will be the initial PA and any services requested after this will be considered continued treatment.

Psychological services will be covered if they are determined medically necessary when using the DSM IV-TR diagnostic criteria. PA approval is based on the DSM IV-TR diagnosis code. However, the diagnosis code on a submitted claim must be the appropriate ICD-9 code.

Up to ten (10) hours of Individual or Family Therapy or a combination of both will be authorized initially for a covered diagnosis of Adjustment Disorder, V-codes, or NOS codes. The intent is to limit any PA to no more than ten (10) hours of Individual or Family Therapy or a combination of the two for these diagnosis codes for any recipient regardless of the provider.

Up to twenty (20) hours will be authorized initially for Individual and Family Therapy or a combination of both for all other covered diagnosis codes. The intent is to limit the first PA to no more than twenty (20) hours of Individual or Family Therapy in any combination for any recipient regardless of provider.

The authorized hours may be divided between Individual and Family Therapy based upon provider request, recipient need and documentation in the treatment plan. This change was effective for dates of service January 01, 2006 and after.

Based upon provider request up to ten (10) hours of Group Therapy will be authorized for a covered diagnosis of Adjustment Disorder, V-codes, or NOS codes.

Based upon provider request up to twenty (20) hours of Group Therapy will be authorized for all other covered diagnosis codes.

Group Therapy may be requested in addition to the Individual and Family request outlined above. The intent is to limit the first PA to no more than twenty (20) hours of group therapy for any recipient regardless of provider.

An additional ten (10) hours of Individual, Family or Group Therapy or any combination may be requested based upon documentation of patient need. PAs for continued treatment (authorizations beyond the initial approved hours) will be based upon review of clinical documentation to include:

- Psychological Services Request for Prior Authorization form
- Current Diagnostic Assessment
- Current/Updated Treatment Plan
- Three (3) Progress Notes reflective of therapy type requested (i.e. requests for additional Family Therapy should include Progress Notes from the three most recent Family Therapy sessions attended by the patient)

PAs for continued treatment will **not** be issued for diagnosis codes including Adjustment Disorder, V codes, or NOS codes.

All documentation submitted must meet the requirements as stated in 13 CSR 70-98-015. Requests submitted with non-compliant documentation as outlined above will result in denial of the request.

The DMS recognizes there are rare instances were Psychological services may be authorized beyond the limits outlined above. For those persons requiring more than the thirty (30) hours of Individual, Family or Group Therapy per year, as discussed above, Clinical Exceptions may be granted based upon documentation of extenuating circumstances.

REQUESTING PRIOR AUTHORIZATION

Providers may deliver four (4) hours of Psychological Services without Prior Authorization to a recipient they have not provided treatment to within the last rolling year. The four (4) hours are intended to assist a provider seeing a recipient for the first time in making the transition to PA should more than four (4) hours be required for treatment. Providers who have been paid for services in excess of four (4) hours for a recipient in the last year will not receive four (4) non-prior authorized hours for that recipient.

Family Therapy without the patient present, Individual Interactive Therapy and **all** Psychological Services for recipients age 0 through 2 years are not included in the four (4) non-prior authorized hours and continue to require PA.

The claims for the four (4) non-prior authorized hours should be submitted and payment established prior to submitting claims for any prior authorized hours/services.

If services are required beyond the initial four (4) non-prior authorized hours, the provider must request a Prior Authorization. To request an initial *PA* you or a staff member may call (866) 771-3350. Although not mandatory, you should complete the Psychological Services Request for Prior Authorization form as the information on this form will be required to complete the request for services. Please see the attachment to the May 27, 2005 bulletin, Volume 27, Number 20 for a copy of the PA request form. Telephoned requests will receive an approval or denial at the time of the call. (**If additional information is needed, the caller will be instructed to fax or mail the PA form and required documentation. This PA request will not be approved during the phone call.**

To request continuing services beyond the initial authorization, the Psychological Services Request for Prior Authorization form must be completed and submitted along with the (1) current Treatment Plan, (2) current diagnostic assessment and

(3) copies of the last three (3) Progress Notes reflecting the therapy type being requested.

This documentation may be faxed to: **(573) 635-6516**

or mailed to: Division of Medical Services
PO Box 4800
Jefferson City, MO 65102.

Before requesting additional hours, 75% of the current authorized hours must be used. The PA approves the delivery of the requested services only and does not guarantee payment. The PA must be obtained prior to delivery of services. The recipient must meet eligibility requirements on the date the service is provided and the provider must be enrolled and eligible to bill for the services.

All Family Therapy without the patient present and Individual Interactive Therapy will require the PA Form, current Diagnostic Assessment, current Treatment Plan, and the last three (3) Progress Notes be mailed or faxed.

Providers will not receive a disposition letter when services are authorized or denied via a phone call. An authorization number will be provided. Services that require submission of the PA form and attachments will receive a disposition letter after review. When PA requests are denied partially or in full, the client will receive a letter outlining the reason for denial and their appeal rights. **Do not give clients the provider Prior Authorization Request telephone number or fax number. Their contact information will be listed in their denial letter.**

If the client is changing providers, the provider listed on the current PA must end that PA before the new provider can be issued a PA. If the current provider refuses to close the PA, the new provider must submit a signed release from the client, requesting a change in provider, in order to close the current PA. The signed release must include the client DCN, type of therapy to be closed and the name of the therapist whose authorization is to be closed.

If a provider needs to change a PA, the provider may call or fax in the information to request a change. The client's name, DCN, type of therapy, what the current PA says, and the requested change must be indicated.

When a client changes providers any available units will be transferred from the closed PA to the new providers approved PA. The new provider will not receive an additional 10 or 20 hours for therapy. The intent is to limit therapy services for any recipient regardless of provider. However, Clinical Exceptions may be granted based upon documentation of extenuating circumstances.

A client may have an open PA with one provider for Individual Therapy and/or Family Therapy and a second PA open with the same or different provider for Group Therapy.

Do not request overlapping dates from a previous PA; overlapping dates will cause the new PA request to deny.

Most Prior Authorizations will be requested using the individual (49) provider number. Private non-FQHC clinics/groups with a provider number beginning 50 must request prior authorization using the individual (49) provider number. However, authorization for services being rendered by a member of an FQHC must be requested by using the FQHC (50) provider number. Services being rendered by a member of an RHC must request Prior Authorization using the RHC (59) provider number.

Prior Authorization is required even when there is coverage through a third party insurance (i.e. Blue Cross/Blue Shield; Prudential). Medicare is not considered third party insurance; however, if there is no PA and Medicare does not cover the service, Medicaid cannot pay.

Prior Authorization is required for clients residing in a nursing home but the psychology/counseling services may not be provided at the nursing home. **Psychiatrists and PCNS may provide pharmacologic management, procedure code 90862, in the nursing home setting.**

Providers may only bill for services they personally provide. Medicaid does not cover services provided by someone other than the enrolled provider. Services provided by an individual under the direction or supervision of an enrolled provider are not covered.

Prior Authorization Exceptions

In-patient hospital stays

Crisis intervention

Testing

Assessment

Procedure codes with a medical evaluation and management service component

Pharmacologic management

Narcosynthesis

Electroconvulsive Therapy

Services covered and reimbursed by Medicare; if Medicare denies services a PA would be required for Medicaid to reimburse.

GUIDELINES – Children

The Division of Medical Services (DMS) has made PA requirement changes for Psychological Services for children and will be implementing additional changes for children. Previous policy, new policy changes, and planned changes are outlined below.

Effective November 01, 2004, Individual Therapy, Family Therapy with the patient present, and Group Therapy required Prior Authorization for children under the age of three (3) when performed by a Psychiatrist, Psychologist, and Psychiatric Clinical Nurse Specialist.

Effective November 01, 2004, Family Therapy without the patient present requires Prior Authorization when provided by a Psychiatrist, Psychologist, Psychiatric Clinical Nurse Specialist, regardless of the **age of the client**.

Family Therapy without the patient present, regardless of the age of the child, has always required Prior Authorization when provided by an LCSW, LPC, PLCSW, PLPC, RHC, or FQHC. This policy remains in effect.

Prior Authorization has always been required for Individual Therapy, Family Therapy with the patient present, and Group Therapy for children under the age of three (3) when services are provided by an LCSW, LPC, PLCSW, PLPC, RHC or FQHC.

When requesting Prior Authorization Psychological services will be covered if they are determined medically necessary when using the DSM IV-TR diagnostic criteria. However, the diagnosis code on a submitted claim must be the appropriate ICD-9 code.

Testing services are not covered when provided by a PLCSW, LCSW. PLPC, or LPC regardless of the age of the client.

All services for children under the age of three (3) and Family Therapy without the patient present require the PA Form, current Diagnostic Assessment, current Treatment Plan, and the last three (3) Progress Notes be mailed or faxed.

An authorization number will be provided. Services that require submission of the PA Form and attachments will receive a disposition letter after review. When PA requests are denied partially or in full, the client will receive a letter outlining the reason for denial and their appeal rights. **Do not give clients the provider Prior Authorization Request telephone number or fax number. Their contact information will be listed in their denial letter.**

Do not request overlapping dates from a previous PA; overlapping dates will cause the new PA request to deny.

If the client is changing providers, the provider listed on the current PA must end that PA before the new provider can be issued a PA. If the current provider refuses to close the PA, the new provider must submit a signed release from the client, requesting a change in provider, in order to close the current PA. The signed release must include the client's DCN, the type of therapy to be closed, and the name of the therapist whose authorization is to be closed.

If a provider needs to change a PA, the provider may call or fax in the information to request a change. The client's name, DCN, type of therapy, what the current PA says, and the requested change must be indicated.

Most Prior Authorizations will be requested using the individual (49) provider number. Private non-FQHC clinics/groups with a provider number beginning 50 must request Prior Authorization using the individual (49) provider number. Authorization for services being rendered by a member of an FQHC (Federally Qualified Health Care) must be requested by using the FQHC (50) provider number and the performing provider name. Services being rendered by a member of an RHC (Rural Health Clinic) must request prior authorization using the RHC (59) provider number.

Prior Authorization is required even when there is coverage through a third-party insurance (i.e. Blue Cross/Blue Shield; Prudential). Medicare is not considered a third-party insurance; however, if there is no PA and Medicare does not cover the service, Medicaid cannot pay.

Prior Authorization has always been required for Individual Therapy, Family Therapy with the patient present, and Group Therapy for children under the age of three (3) when services are provided by an LCSW, LPC, PLCSW, PLPC, RHC or FQHC. This policy remains in effect.

Prior Authorization is required for clients residing in a nursing home but the Psychology/Counseling services may not be provided at the nursing home. **Psychiatrists and PCNS may provide pharmacologic management, 90862, in the nursing home setting.**

Providers may only bill for services they personally provide. Medicaid does not cover services provided by someone other than the enrolled provider. Services provided by an individual under the direction or supervision of an enrolled provider are not covered.

Prior authorization is required for Psychological services provided on public school district grounds when billing to Medicaid. The provider must have a separate Medicaid provider number with a pay-to of the school district.

Prior Authorization Exceptions

Inpatient hospital stays

Crisis intervention

Testing

Assessment

Procedure codes with a medical evaluation and management service component

Pharmacologic management

Narcosynthesis

Electroconvulsive Therapy

Services covered and reimbursed by Medicare; if Medicare denies services a PA would be required for Medicaid to reimburse.

Effective for dates of service December 01, 2005 and after, Testing and Diagnostic Assessment (Insight-90801) have been removed for the Prior Authorization process for most clients.

Diagnostic Assessment (Interactive-90802) continues to require Prior Authorization regardless of the age of the client.

All services for all children under the age of three (3), including those in state custody and residential care facilities, continue to require Prior Authorization. This includes Testing and Assessment services.

State Custody Medicaid Eligibility (ME) Codes

At this time ME codes 07, 08, 29, 30, 35, 36, 37, 50, 51, 52, 53, 54, 56, 57, 63, 64, 66, 86, 69, 70, are exempt from Prior Authorization requirements due to the child being in state custody. When verifying eligibility, if the ME code is **not** one of these, regardless of other source information, you **must** request Prior Authorization.

Prior Authorization Policy for Children 0 through 20

Effective May 01, 2005, the Division of Medical Services implemented a prior authorization process for all children birth (0) through 20 who are not in state custody or residing in a residential treatment facility. Except for those situations previously indicated, Prior Authorization requirements for children in state custody or in a residential facility will be implemented at a later date. Future Psychotherapy bulletins will address enrollment of these additional populations.

The PA process includes services provided by a Psychiatrist, Psychologist, PCNS, PLCSW, LCSW, PLPC, LPC, RHC, and FQHC.

The first four (4) hours of Psychological services for most children and services do not require Prior Authorization. These four (4) hours are intended to assist a provider seeing a patient for the first time make the transition to PA should more than four (4) hours be required for treatment. These four (4) hours may consist of Individual Therapy, Group Therapy or Family Therapy. The first four (4) hours is per recipient, per provider, per rolling year. Providers who have been paid for services in excess of four (4) hours for a patient in the last year will not receive four (4) non-Prior Authorized hours for that client.

This does not apply if providing services to children under the age of 3, Individual Interactive Therapy, or Family Therapy without the patient present. All hours for these services must be prior authorized.

The claims for the four (4) non-prior authorized hours should be submitted and payment established prior to submitting claims for any prior authorized hours/services.

After the initial 4 hours, when it is determined that ongoing services are medically necessary, Prior Authorization must be obtained. This Prior Authorization must be requested before rendering additional services. In order not to interrupt services it would be best to request authorization before all 4 hours are used. The first PA request will be the initial authorization and any services requested after this will be considered continued treatment. Except for those situations indicated above the preferred method of therapy may be requested by calling the Psychological Services Prior Authorization telephone number.

You or a staff member may place the call but the Psychological Services Request for Prior Authorization (PA) Form, although not mandatory, should be completed as the information on this form will be required to complete the request for services. Telephoned requests will receive an approval or denial at the time of the call. If additional information is needed the caller will be instructed to fax or mail the PA form and required documentation. This PA request will not be approved during the phone call.

Prior authorization of Psychology/Counseling services for children is based on the age of the child and the type of therapy requested. Based on these limitations the first request for PA can include Individual, Family, and Group Therapy.

Assessment and Testing for a child under the age of 3 must be prior authorized and providers must submit clinical justification for providing these services. Prior Authorization does not allow the provider to exceed the unit limitations for these services.

To request continuing services after the initial authorization, the Psychological Services Request for Prior Authorization Form must be completed and submitted along with the current Treatment Plan, current Diagnostic Assessment and copies of the last three (3) Progress Notes. If the services being requested are court ordered, a copy of the court order must also be attached. Before requesting additional hours, 75% of the current authorized hours must be used.

Approval will be based on the DSM IV-TR diagnosis code. Up to ten (10) hours of Individual Therapy will be allowed for a diagnosis of Adjustment Disorder, V-codes, or NOS codes. Up to twenty (20) hours will be allowed for all other covered diagnosis codes. Family and Group Therapy will be approved for up to 10 hours for all covered mental health diagnoses. The authorized number of hours is based on the primary diagnosis and your documentation must support the diagnosis code.

Providers will not receive a disposition letter when services are authorized or denied via a phone call. An authorization number will be provided. Services that require submission of the PA form and attachments will receive a disposition letter after review. When PA requests are denied partially or in full, the client will receive a letter outlining the reason for denial and their appeal rights. **Do not give clients the provider Prior Authorization Request telephone number or fax number. Their contact information will be listed in their denial letter.**

Children are best treated within the environment in which they live. Clinical evidence suggests family intervention is superior to individual therapy in treating children with many psychological disorders. Therefore, treatment should support the child within the family whenever possible. Clinical evidence also suggests treatment must be based upon age and cognitive development of the child. Best Practice approaches should insure the coordination of care when multiple providers are involved with the same child/family.

Group therapy uses group dynamics and peer interactions to increase understanding and improve social skills.

Multiple therapies are the treatment of the individual with more than one therapy such as Individual and Family, simultaneously within the same authorization

period. The treatment plan must document the medical need for more than one therapy. There is no procedure code that specifies multiple therapies are being requested.

When requesting prior authorization for multiple therapies the Prior Authorization Request Form must be completed and faxed or mailed, along with the requested documentation, to DMS. The PA request needs to indicate all types of therapy being requested.

If a child's age changes during the prior authorization period, the prior authorization will continue as authorized. However, if the child turns 21 during the authorization period, the policy on age restriction for certain providers will apply. LPCs and LCSWs who are restricted to seeing children under the age of 21 will not be paid for services performed on or after the date the child reaches the age of 21 even if prior authorized.

Prior Authorization by Age Group

Psychology/counseling services for children under the age of 3, Family Therapy without the patient present and Individual Interactive Therapy will not be allowed under the 4 hours of non-prior authorized service. The preferred method of treatment is indicated first and if no documentation is required a telephone call may be made to request Prior Authorization. Services other than the preferred method and multiple therapies will require the PA Form and documentation be submitted via fax or mail.

Children Birth through 2

- Family Therapy authorized initially with documentation and review
- Individual Therapy will not be authorized
- Group Therapy will not be authorized

Children 3 through 4

- Family Therapy authorized initially without submitting documentation
- Individual Therapy will not be authorized with the exception of Interactive Therapy with documentation and review. Your documentation must support the reason why Individual Interactive Therapy is being provided
- Group Therapy will not be authorized

Children 5 through 12

- Family Therapy authorized initially without submitting documentation
- Group Therapy authorized initially with documentation and review
- Individual Therapy authorized initially with documentation and review
- Multiple therapies authorized initially with documentation and review

Children 13 through 17

- Individual Therapy authorized initially without submitting documentation
- Family Therapy authorized initially without submitting documentation
- Group Therapy authorized initially with documentation and review
- Multiple therapies authorized initially with documentation and review

Children 18 through 20

- Individual Therapy authorized initially without submitting documentation
- Family Therapy authorized initially with documentation and review
- Group Therapy authorized initially with documentation and review
- Multiple therapies authorized initially with documentation and review

Prior authorization requests may be made by calling: **(866) 771-3350**
OR submitting the PA form and required documentation to:

Mail: Division of Medical Services
PO Box 4800
Jefferson City, MO 65102
Fax: (573) 635-6516

Prior Authorization Tips

Children under the age of 3 always require a PA form and documentation. Testing and Assessment will also require clinical justification.

Call for approval on an initial Prior Authorization when the service does not require documentation.

If requesting Prior Authorization for multiple therapies fax or mail the PA form along with all required documentation even though it may be the initial request. When a PA request has been faxed or mailed allow sufficient time for the request to be reviewed. Do not send duplicate requests; expect at least five (5) days for a reply. You may call any/either of the following numbers to check on the status of a PA request:

Provider Communications	**(573) 751-2896**
Provider Education	**(573) 751-6683**

When faxing PA requests only send one (1) at a time. Multiple requests on the same fax must be handled differently and result in additional delay in response. Don't fax questions to the Psych Help Desk-send through Ask DMS e-mail.

Review the documentation requirements to insure all aspects have been included, are easily identified, and that appropriate documentation is being submitted with your prior authorization request.

Documentation is required for all services for children under 3, multiple therapies, continuing therapy, and non-preferred therapy. The required documentation is the current Diagnostic Assessment, current Treatment Plan, and the last 3 Progress Notes. If the Psychological services being requested are court ordered, a copy of the court order must also be attached to the documentation.

If a child's age changes during the authorization period the Prior Authorization will continue as authorized. **BUT** if the child turns 21 during the authorization period the policy for age restrictions will still apply even when services are prior authorized.

Prior Authorization requests will not be backdated. Allow sufficient time for submission and review of the PA and documentation. This includes enough time to resubmit the PA and documentation in the event the first submission is denied.

Daily and monthly limitations still apply even though an authorization has been approved.